MEDICAL HISTORY QUESTIONNAIRE

Mountain View EYE CENTER

Patient Legal Name: _____ Today's Date: _____

Patient Preferred Name: _____ Date of Birth: _____

Occupation: _____ Hobbies: _____

Tobacco Use: □ never used □ formerly used Year Quit: _____ Years of Tobacco Use: _____

□ cigarette □ electronic/vaping □ cigar □ pipe □ smokeless (chew) Average use per day: _____

FAMILY HISTORY Place an 'X' in the appropriate box as it applies to your blood relatives:

□ **family history is unknown**

	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Glaucoma							
Macular Degeneration							
Retinal Detachment							
Strabismus (crossed eye)							

PERSONAL HISTORY Check any that apply to you:

EYES
□ amblyopia
□ double vision
□ dryness
□ glaucoma
□ iritis/uveitis
□ keratoconus
□ ocular trauma
□ macular degeneration
□ retinal detachment
□ retinitis pigmentosa
□ strabismus (crossed eye)

□ wear glasses
□ wear contact lenses

ENDOCRINE
□ diabetes □ type I □ type II
Year diagnosed: _____

□ thyroid disease
□ rheumatoid arthritis
□ lupus
□ graves disease
□ multiple sclerosis
□ other: _____

CARDIOVASCULAR
□ angina or heart attack
□ high blood pressure
□ high cholesterol
□ irregular heart beat
□ stroke

NEUROLOGIC
□ headaches
□ migraines
□ Bell's palsy
□ brain tumor
□ dementia
□ shingles/herpes zoster affecting the head or face

GENITOURINARY
□ ever used Flomax (tamsulosin)
□ ever used Cardura (doxazosin)
□ ever used Hytrin (terazosin)
□ ever used medication for prostate

GASTROINTESTINAL
□ Crohn's Disease
□ ulcerative colitis

RESPIRATORY
□ asthma
□ COPD

Eye Drops (including over the counter): _____
Other Medications (including over the counter): _____
_____
_____
_____
Allergies: □ latex □ seasonal allergies Medication Allergies: _____
Past Eye Injuries: _____
Past Eye Surgeries (include dates): _____